Rate System Overview

Department of Developmental Services

Presentation

- Brief History
- Reasons for adopting a rate-based methodology
- Provider Input
- Rates – Where we started and where we are today

Brief History

- DDS has used a waiver to help finance community living arrangements and day services since 1986 as an alternative to ICF/MR
- Over time, millions of dollars of service were being delivered without taking advantage of federal reimbursement offered under the waiver

Brief History

- A number of DDS events converged that influenced the move to a new system:
  - 2000 Waiting List Focus Team Report
  - Self determination took hold in CT
  - ARC/CT Waiting List Lawsuit settlement in 2005
  - Governor and Legislature Waiting List Initiative began in 2005
  - New CMS guidelines published in 2005

Brief History

- DDS was approved for the Individual and Family Support (IFS) Waiver and the Comprehensive Waiver in 2005
- All individuals enrolled in the original DDS waiver were enrolled into either the Comprehensive or IFS Waiver on October 5, 2005
- Fee For Service Rates were developed for the new waivers

Factors that lead CT to move to a rate based system

- Individual's portability through the system was hindered by variable funding.
- Choice was more difficult
- Portability to a more expensive program cost DDS additional money
- Built-in incentive not to provide services
- Wage disparity among providers
- Turnover
- Impact on Quality of Care

Provider Input into the Process

- Provider Council began discussing the new waivers and the effect on providers since 2004
- Waiver Work Group- A subgroup of the Provider Council was formed on April 1, 2005 to review the rate methodology for the IFS Waiver and begin discussing the CLA rates

Fee for Service Rates Where We Were

- The Initial Fee for Service Rates were effective in April 2005
- The rate methodology was based around the direct care salary with adjustments for supervision, benefits, indirect expense and administrative and general costs
- The initial rate methodology used one hourly rate for each service
- Providers billed for each hour of service

Fee for Service Rates Where We Were

- From the recommendation of the Waiver Work group, the initial rates were recalculated to account for higher supervision and a lower utilization rate effective on July 1, 2005
- Additional changes were made to the original approach:
  - **Staffing Modifier was added**
  - **Transportation was changed from one way to a round trip**
  - **Added a Handicapped accessible transportation rate**
  - **Summer camp was added as a service that can utilize respite rates based on LON**
  - **Added a mechanism to fund an additional staff for transportation needs**
  - **Added a 2 person rate for Out of Home Respite**

Fee for Service Rates Where We Were

- A revised rate methodology was developed in 2007 to utilize the Level Of Need to determine staffing levels
- DDS asked providers to complete a rate analysis on the new rates
- The lesson learned from the rate analysis was the need for multiple rates to reduce the size of the gap in funding between each rate

Where We Are Today

- Day providers are funded two different ways:
  - ♦ Vendor Service Authorizations
  - ♦Purchase of Service Contract

Where We Are Today

- Vendor Service Authorizations
  - Must be a qualified provider
  - A separate authorization for each individual
  - Individual allocation based on Level of Need and IFS Waiver Rates
  - Providers bill Fiscal Intermediary
  - One invoice for each individual based on the hourly rate of the authorized service in 15 minute intervals

Where We Are Today

- Purchase of Service Contracts
  - Standard contractual language
  - Individual allocations based on either a historical funding or Level of Need basis
  - Providers are reimbursed based on utilization of service for all participants on a monthly basis
  - No billing invoices
  - Payment based on utilization (previously was based on 1/12 of the annualized amount of the contract plus any one time non-annualized adjustments)

Why Utilization Payments?

- The move to utilization payments for Purchase of Service Day Contracts is being implemented to ensure that the appropriate amount of supports is provided in the most cost effective manner for those individuals who attend the program.

Why Utilization Payments?

- This eliminates the incentive not to increase attendance in order to maintain a staffing ratio higher than the supports required by the participants in the program for a given day.
- This eliminates a financial incentive for lower attendance.

Why Utilization Payments?

- Targeted reductions based on utilization ensure the best value for the taxpayer's dollar while providing the most service possible to individuals and families.
- Encourages providers to maximize supports to the individuals they serve
- Maximizes Medicaid reimbursement
- Allows for more accuracy in billing Medicaid for only the supports provided

Where we were headed last Spring

- Use Level of need to Determine funding
- Transition of system over 5 years
- Utilization based payments
- Safeguards for lower rate providers during the transition

Level Of Need

- Determine an individual's need for supports in an equitable and consistent manner for the purposes of allocating DDS resources
- Identify potential risks that could affect the health and safety of the individual, and support the development of a comprehensive Individual Plan to address potential risks
- Identify areas of support that may need to be addressed to assist the individual in actualizing personal preferences and goals
- Rates developed for each Level of Need

Fee for Service Rates

- A new rate system incorporating the original methodology was developed
- The rates were based on each individual's Level of Need
- The rates for group day programs were an all inclusive per diem rate that included transportation and staffing enhancements
- The rates for GSE and DSO were the same
- The former Supported Living service was split into Individualized Home Supports (intermittent supports) and Continuous Residential Supports (24 hour SL)
- A new web based attendance reporting system was developed for Medicaid reporting and to simply the billing for providers

Transition Plan

- **Goal: Allow providers to successfully adapt to the new fee for service system through a gradual change in historical reimbursement levels.**

Transition Plan

- **2010 - 2% increase or reduction or adjust to rates if difference is less than 2%. Any additional resources available from system change will be used to address low rate providers.**
- **2011 - 20% of the transition factor (after the first year) from rate or 2% whichever is greater or move completely on to the rate if the difference is less than 2%.**
- **2012 - 20% of the transition factor (after the first year) from rate or 2% whichever is greater or move completely on to the rate if the difference is less than 2%**
- **2013 - 20% of the transition factor (after the first year) from rate or 2% whichever is greater or move completely on to the rate if the difference is less than 2%.**
- **2014 - 20% of the transition factor (after the first year) from rate or 2% whichever is greater or move completely on to the rate if the difference is less than 2%.**
- **2015 - Providers paid at the rates. (last 20%)**

Safeguards

- Transition floor
- Transition Ceiling
- Utilization capped at 80%
- Agency Hardship